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B- Katja Fox

GNMH Greater Nashua Mental Health

November 5, 2019

State of New Hampshire
Department of Health and Human Services
Office of Human Services
Division of Child Youth & Families
129 Pleasant Street
Concord, NH 03301-3857

Dear Commissioner Meyers:

I am writing this letter to provide you with information in response to *RFI-2020-DCYF-01-REDES-01*. In particular, I urge you to partner with the NH Child-Parent Psychotherapy (CPP) Provider Network, led by nationally certified CPP trainers, Martha Robb, Ph.D., and Cassie Yackley, Psy.D, to make CPP (an evidence-based intervention for children and caregivers with trauma exposure) part of your service array for children zero to six and to support their ongoing efforts to grow and sustain CPP capacity across NH.

Currently, CPP is the only evidence-based intervention for children exposed to trauma ages zero to six that we offer. It has helped us be more responsive than reactive to the increase in demand for services in this age group connected with the opioid crisis. Our adoption of CPP has not only allowed us to build our capacity to address the neurodevelopmental needs of young children, but also offer unprecedented continuity of care. Through CPP we can address both developing healthy parenting relationships with caregivers and the safety and attachment needs of the child through working with multiple caregivers simultaneously (offending parents, non-offending parents, foster parents, adoptive parents, grandparents, etc.) and through the array of caregiver relationship transitions the child moves through (e.g., removal, placement, reunification, termination, adoption, etc.). Our experience suggests that this continuity of care can both help limit the amount of time children are in placement outside of their home or keep children out of placement. We believe it essential that NH DCYF has CPP in its service array in all regions of NH.

CPP has been a powerful model for our clinicians. It has offered them hope in the effort to stop

multigenerational transmission of trauma. Our clinicians have been excited both to learn and employ this intervention. As we have seen progress in some of the most challenging and complex cases with this model, this excitement has transformed into momentum for further growth. Our agency adopted Child Parent Psychotherapy (CPP) in 2015. Since initially rostering our first 3 clinicians, our team has grown to 6 clinicians. We now have enough clinicians to form an in-house team for consultation and supervision, which will significantly support the sustainability of the model at our agency.

Through the Network and its support from Behavioral Health Improvement Institute (BHII) our agency has been able to receive ongoing training, including advanced training, consultation and several other forms of support to develop our capacity to provide CPP, including:

- offering, to date, three 18-month CPP Learning Communities, each of which involves 2 national-certified CPP trainers (Yackley and Robb) providing 7 full-day trainings and bi-monthly supervision, which have rostered (qualified) each of our CPP clinicians
- developing an online fidelity tracking and data management system
- Offering guidance and support with outcome measurement
- assessing and providing feedback regarding agency readiness for CPP implementation and subsequent sustainability
- boosting clinician retention/job satisfaction (through the Network, Yackley & Robb have offered leadership in and advocacy for CPP that has fostered the development of a supportive, cross-agency professional community of NH CPP clinicians)
- disseminating information to the public about CPP and maintaining a website listing CPP providers in NH
- facilitating both in-state, and out-of-state "warm hand-offs" to new CPP providers when clients move

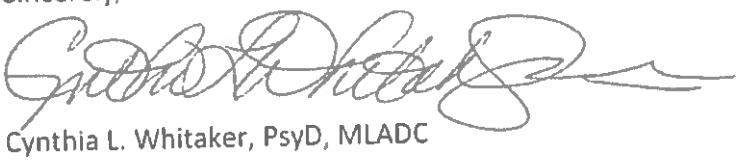
Through BHHI, the Network has provided these supports with *no cost* to the agency through several federal- and state-level grants and private donations. Simply put, we **would not** be able to grow our CPP team (not to mention we most likely would not even have a CPP team) if we were required to fully fund the cost of new clinicians attending the LC and ongoing training and consultation for rostered clinicians.

There are key components of CPP growth and sustainability that are beyond the scope of BHII's and the Network's support with implementation and sustainability. Case management and care coordination are fundamental components of CPP. The associated indirect costs of such collateral work would be a barrier to growth and sustainability of the model at our agency. Similarly, the indirect costs related to the training provided by the Network would also be a significant barrier to growth and sustainability (e.g., reimbursements for travel, indirect training

costs, and other costs associated with the group reflective supervision and consultation processes).

We urge your consideration of Dr. Yackley's response to your RFI. Yackley and the Network's efforts have helped to fill a long-standing gap in NH's mental health service array for intervention and prevention with traumatized young children and their families. We strongly believe that CPP should be one of the primary models DCYF supports in their service array reconfiguration efforts.

Sincerely,



Cynthia L. Whitaker, PsyD, MLADC
Chief of Services
Greater Nashua Mental Health

GNMH Greater Nashua Mental Health

State of New Hampshire
Department of Health and Human Services

RE: RFI-2020-DBH-01-MOBIL SUBMISSION

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GNMH Greater Nashua Mental Health

Executive Summary:

This is a limited response to DHHS' request for information specifically in regard to the provision of mobile crisis response services to the Deaf and Hard of Hearing population. The Deaf and Hard of Hearing Services Team (known as the DST) provides culturally and linguistically competent mental health services to the targeted population statewide, designated at GNMH since its implementation in 1995. This team is the only team of qualified signing providers able to provide specialized community-based mental health services directly to those who are deaf and hard of hearing via American Sign Language (ASL). This program serves all ages (children & adults) and family members of those who are deaf. Coordinated by Holly Rioux, LICSW, the team of deaf and/or signing clinicians and case managers provides individual and family therapy, substance use counseling, case management, functional supports, crisis support, and access to integrated care. Our clients also have access to psychiatry at GNMH with a qualified mental health interpreter of ASL on staff.

As the Department of Behavioral Health has designated GNMH to serve our statewide community, it is our intention to provide information for your consideration during the exploration of a statewide mobile crisis team. We believe we have experience in statewide service delivery and encourage strong and effective collaboration as part of its model as the state strives to effectively serve its Deaf and Hard of Hearing Community. Most of the potential solutions offered in this response are already in practice here at GNMH.

Please note that this is not a complete response as we are not proposing a dedicated statewide mobile crisis response team for the Deaf and Hard of Hearing. Rather, we aim to share some insights and challenges to our crisis response and overall service delivery as they exist currently in a statewide model. Below are answers to select questions with emphasis on Factors to Consider, as outlined in Section 4 of RFI-2020-DBH01-MOBIL. We support designing protocols for working with the Deaf and Hard of Hearing individuals who are in crisis during the implementation phase as this will enable us to assure our community that there will be a coordinated response to critical incidents.

The Deaf Services Team at GNMH has over 25 years of experience treating individuals across the entire lifespan and geographic regions of New Hampshire. We look forward to collaborating with whatever statewide mobile crisis system is developed to ensure that all services, including crisis services, are provided in linguistically and culturally respectful ways. Please do not hesitate to contact us throughout the design and implementation process.

GNMH Greater Nashua Mental Health

Q1. Briefly describe your organization, who you serve, and any experience/expertise specific to behavioral health crisis response services. Please keep generalized marketing material to a minimum.

The Deaf and Hard of Hearing Services Team (DST) provides culturally and linguistically competent mental health services to the targeted population statewide, designated at GNMH since its implementation in 1995. This team is the only team of qualified signing providers able to provide specialized community-based mental health services directly to those who are deaf and hard of hearing via American Sign Language (ASL). This program serves all ages (children & adults) and family members of those who are deaf. Coordinated by Holly Rioux, LICSW, the team of deaf and/or signing clinicians and case managers provides individual and family therapy, substance use counseling, case management, functional supports, crisis support, and access to integrated care. Our clients also have access to psychiatry at GNMH with a qualified mental health interpreter of ASL on staff.

Q2. Describe any experience/expertise or lessons learned in operating mobile crisis response services and/or statewide integrated teams specific to the Factors to Consider listed in Section 4.

4.1.1: Clinical need

Though our population is small in our rural state, crisis support is critical to equitable and effective service delivery, and positive treatment outcomes. Even though there is not a need for a dedicated crisis response team for this population due to low incidence, it is imperative that DHHS considers this targeted population and collaboration with an existing statewide team during implementation phases.

Currently, our team provides crisis services as needed mostly during business hours and relies on the support of GNMH's Emergency Services after-hours. GNMH's ES team receives technical and cultural training so they are prepared to receive a call from a deaf or hard of hearing person. Protocols are in place for DST providers to follow up with the client as early as the next business day. While collaboration works well internally, there are challenges with logistics and varying protocols at different ERs and CMHC's should the client reside outside of GNMH's catchment area.

Below are some considerations and proposed solutions to strive towards equitable mental health crisis response services for the Deaf and Hard of Hearing population of all ages statewide as they apply to various Factors to Consider.

4.1.13. Accessibility for currently underserved populations including, but not limited to people who identify as lesbian, gay, bisexual, transgender, and questioning (LGBTQ); transitional age youth and young adults; pregnant women with behavioral health conditions; racial, ethnic and linguistic minorities.

and

4.1.2. Cultural needs of people in crisis and their families.

Our clients need access to crisis support in their primary language which is often American Sign Language (ASL). Not only is linguistic competency in crisis intervention required, knowledge and specialized clinical skills are needed. Responding to a crisis requires understanding an experience of a deaf or hard of hearing person, particularly as they navigate challenges in interacting within their primarily hearing families. It is widely known that 90% of Deaf individuals are from predominately hearing families, and 90% of those hearing family members do not communicate in sign language well enough to have a full conversation with their Deaf family member. Therefore it is critical that our providers are able to respond to crises with special care and consideration for the intricacies this dynamic often presents. These especially must be considered in cases of domestic and sexual violence, and child welfare.

When a Deaf, signing individual is in crisis, we have found adults may be more likely to "ride out the crisis" with our supports currently available, however limited, before seeking a higher level of care. This is due to severely limited options for culturally competent mental health services for our population available in our state. The therapeutic rapport with the DST provider is often deemed more desirable than seeking emergency support with non-competent providers at local ERs or other treatment facilities.

4.1.16. Relationships or partnerships with other types of providers (law enforcement, hospitals, first responders, community organizations, etc.)

To serve our population effectively and equitably in a crisis, collaboration between the DST and crisis providers, including ER providers, CMHC emergency clinicians and mobile crisis teams, is critical for consultation, sharing of pertinent clinical and cultural information, treatment and discharge planning. We have had unfortunate incidents during which our clients were served by a mobile crisis response team outside of our agency and we were not informed in a timely manner. Barriers we faced included:

- the other agency's internal protocol requiring an authorization to release information (ROI) despite our state designation delaying the sharing of information;
- providers not knowing of our program's existence or assumption that our services were limited to GNMH catchment;
- providers feeling their response to the client was adequate;
- providers not able to adequately assess crisis risk due to communication barriers.

Developing a strong and responsive partnership with language access providers such as interpreting referral agencies, and qualified mental health ASL interpreters in various parts of the state is critical to ensure equitable and effective care during crisis response.

4.1.3. Approaches and tools used for different populations.

The DST is unique in that services are provided all over the state, not limited to GNMH catchment area. We have observed our ability to communicate with our clients via videophone as a critical asset that supports our timely response to a client who may be in crisis or in need of support. This telehealth model has historically served as advantageous; we are able to see our client's physical presentation and surroundings, as opposed to a hearing caller relying only on listening with their hearing clients. However, there are considerations at varying stages for this model to be effective in each case. The client must have access to high speed internet at home, or a strong cellular network with a smartphone, which negatively impacts those in rural settings. Additionally, we must consider their home surroundings may not be safe for crisis intervention.

Currently, each team member has a videophone and smartphone with capabilities to work remotely in the state. Communicating electronically with our clients to check in on safety and wellbeing in instances where phone contact is not available has been effective as well.

Technological capabilities enable us to strive for equity in serving a linguistic minority directly in the target language.

4.1.9. Technology infrastructure needs.

While we may be able to access borrowed offices at some CMHC's, we are still connecting remotely via cellular hotspots. Not all CMHC's and hospitals have adequate cellular service to access an electronic health record. Therefore, one suggestion to consider is a statewide team's authorization to access secure internet access points via local hospitals and CMHCs.

This is a typical challenge we've faced in working with privately contracted agencies on a regional basis. Statewide implementation must include a statewide mobile/technological network not limited to cellular hotspots.

4.1.4. Approaches and ideas regarding the provision of service in a community-based setting rather than in a person's home.

Currently, some public sites, such as hospital lobbies, provide a videophone for the public to access. Increasing the number of videophones in both public and private settings would support a deaf person's access to crisis services as well as our providers' ability to provide critical outreach and crisis support from varying parts of the state.

Currently, the DST is able to establish relationships with some CMHC's to borrow existing office space to serve clients in various parts of the states. This allows clients to receive services in a therapeutic setting close to their home and DST to be reimbursed appropriately for in-office services. Limitations to this model are impacted by overcrowded offices, limited to their business hours and availability, and the need to develop and maintain collaborative relationships with office managers and program supervisors at all CMHCs.

A videophone at each CMHC would further support service delivery. Support from the state to encourage all CMHCs and primary care offices to foster this collaboration and provide space for service delivery would enhance timely access to care.

DST has experience in providing clinical and crisis services in the home as this approach supports the norms within Deaf Culture and the community. DST is skilled in establishing boundaries and parameters for effective treatment interventions in such a setting.

The Mental Health in Schools model is also worth considering. A deaf or hard of hearing child having access to a signing provider during school hours has many intrinsic benefits. Again, this requires collaboration with the schools to use space. Schools having a dedicated space for local crisis responders and mental health providers would be beneficial. This space could also include a videophone for the child and signing provider to connect via American Sign Language. This would be a far more timely and efficient response to assess for acuity, plan for safety, provide crisis support opposed to being limited to travelling and scheduling constraints that are not conducive to effective crisis response.

Overall, it is critical to have multiple modalities available for effective crisis response.

4.1.6. Funding, with an emphasis on maximizing private and public insurance participation.

Unfortunately, because the current program does not have the resources to be available 24/7, the type of support listed above is limited to mostly business hours. Furthermore, there are varying instances where administrative barriers are in place, such as the need for an office to bill for the services being provided, or a licensed provider is required by insurance. Currently there are only two known licensed providers who are Deaf, fluent in ASL and actively serving this population. In-home and community based services are typically only covered by Medicaid. Our population is often supported by Social Security Disability Income, which often puts them into a Medicaid spenddown plan. Those

connected to private insurers often are not covered to receive community based or in-home crisis support. The DST is often burdened with charging off crisis support services that were critically necessary but not covered.

4.1.7. Workforce and staffing needs, for example, staff competencies, areas of expertise, and specialty training requirements.

Members of the statewide mobile crisis response team should receive annual training and consultation from GNMH Deaf and Hard of Hearing Services Team on serving deaf and hard of hearing community members in crisis. This training can include an overview of best practices for treating deaf and hard of hearing individuals and protocols in place for effective collaboration in a statewide model as we serve our community. When utilizing ASL interpreters, the statewide mobile crisis response team should ensure contracted interpreters have demonstrated competency in interpreting in mental health settings, in accordance with nationally accepted mental health interpreting standards. The DST at GNMH has a small but dedicated network of local interpreters who have demonstrated interest to develop their competencies in this area.